Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
William C. Hayden, DC

Respondent Name
Safety National Casualty Corporation

MFDR Tracking Number
M4-14-2975-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
May 28, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We requested a reconsideration from the insurance, Gallagher Bassett, for a claim … 03/25/2013 in the amount of $650.00, for a Designated Doctor Exam. We received partial payment of $0.00. We submitted a reconsideration request on 05/06/2014, for the remaining balance of $650.00. The denial reason(s) per EOB are: *20-National Provider Identifier Missing. **According to DWC RULE 133.10 there is no NPI required in box #17b.**"

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on June 5, 2014. However, no written position statement was received.

Response Submitted by: NA

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 25, 2014	Designated Doctor Exam for Maximum Medical Improvement and Impairment Rating	$650.00	$650.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.10 (f) provides a list of required elements for the medical billing form.
3. 28 Texas Administrative Code §134.204 (j) explains what is required to bill and be reimbursed for an Examination of Maximum Medical Improvement and Impairment Rating (MMI/IR).
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 20 – (206) National Provider Identifier - Missing
   - 16 – (16) Claim/Service lacks information or has submission/billing error(s) which is needed for adjudication.

Issues

1. Did the requestor provide the required information for adjudication of the bill, including National Provider Identifier?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.10 (f)(1)(L), "(1) The following data content or data elements are required for a complete professional or noninstitutional medical bill related to Texas workers' compensation health care: (L) referring provider's National Provider Identifier (NPI) number (CMS-1500/field 17b) is required when CMS-1500/field 17 contains the name of a health care provider eligible to receive an NPI number". CMS-1500/field 17 shows the "referring provider or other source" as "Dallas DWC". Dallas DWC is not a health care provider eligible to receive an NPI number. Therefore, no NPI number is required in CMS-1500/field 17b.

   Per 28 Texas Administrative Code §133.10 (f)(1)(V), "(V) rendering provider's NPI number (CMS-1500/field 24j, unshaded portion) is required when the rendering provider is not the billing provider listed in CMS-1500/field 33 and the rendering provider is eligible for an NPI number". The rendering provider is the same as the billing provider. Therefore, no NPI number is required in CMS-1500/field 24j, although it is provided.

   Per 28 Texas Administrative Code §133.10 (f)(1)(DD), "(DD) billing provider's NPI number (CMS-1500/field 33a) is required when the billing provider is eligible for an NPI number". The billing provider's NPI number is present in CMS-15/field 33a.
2. Review of the submitted documentation finds that the provider included a copy of the examination, consultation with the injured employee, review of the records and films, narrative report, and tests used to assign the IR, as required by 28 Texas Administrative Code §134.204 (j)(1). Therefore, reimbursement for MMI/IR is due.

   Reimbursement for evaluation of MMI is $350.00 per 28 Texas Administrative Code §134.204 (j)(3)(C). Reimbursement for evaluation of IR is $300.00 per 28 Texas Administrative Code §134.204 (j)(4)(C)(ii)(II)(-a-), because the provider performed a full physical examination with range of motion.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $650.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $650.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	December 4, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.